USAble Life
P. O. Box 1650
Little Rock, AR 72203

Please Print Using Dark Ink

# ARKANSAS PUBLIC SCHOOL EMPLOYEES GROUP
## Application, Change Form & Beneficiary Change Form

| For Office Use Only | | |
|---|---|---|
| Class | Dep | SIC |
| Eff. Date | | |
| Group # | | |

**Instructions:**
1. **For $5,000 Basic Life/AD&D *ONLY* – complete yellow areas.**
2. **For $5,000 Basic Life/AD&D *AND/OR* Supplemental Life/AD&D, Dependent Life – complete all areas.**
3. **Return Completed Form to Your School District Payroll Office.**

❑ New Applicant ❑ Benefit Change ❑ Name Change ❑ Beneficiary Change

## APPLICANT INFORMATION

| Employer (Agency /School District Name) | Group Number | Product(s) |
|---|---|---|
| | **AS004404-_____** | ❑ Basic Life/AD&D<br>❑ Supplemental Life/AD&D<br>❑ Dependent Life |

| Employee Social Security # | Employee First Name | MI Initial | Last Name | Date of Birth (Mo Date Year) |
|---|---|---|---|---|
| | | | | |

| Home Address (Street City State Zip) | Birth State or Country |
|---|---|
| | |

| Sex ❑ Male ❑ Female | Height (ft.-in.) | Weight (lbs) | Marital Status | Date of Hire **(Include Month/Day/Year)** | Occupation |
|---|---|---|---|---|---|
| | | | | | |

| Home Phone # | Work Phone # | Annual Salary |
|---|---|---|
| | | |

**Spouse & Children Information –** *Complete if Applying for Dependent's Coverage*

| Person Proposed for insurance Show first, middle, last name | Social Security # | Occupation | Date of Birth & Place | | | | Height | Weight | Marital Status | Sex |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Mo. | Day | Yr. | State or Country | | | | |
| (spouse) | | | | | | | | | | |
| (child) | | | | | | | | | | |
| (child) | | | | | | | | | | |
| (child) | | | | | | | | | | |

## SUPPLEMENTAL/DEPENDENT LIFE

### Supplemental Employee Life and AD&D

| Classification By Basic Annual Earnings | Insurance Amount | Check One | Monthly Premium |
|---|---|---|---|
| $10,000 or less | $20,000 | ❑ | $ 5.00 |
| $10,001 - $15,000 | $30,000 | ❑ | $ 7.50 |
| $15,001 - $20,000 | $40,000 | ❑ | $10.00 |
| $20,001 - $25,000 | $50,000 | ❑ | $12.50 |
| $25,001 - $30,000 | $60,000 | ❑ | $15.00 |
| $30,001 and above | $70,000 | ❑ | $17.50 |

### Dependent Life

❑ Yes ❑ No

Spouse : $2,500

***Your spouse/child will not be covered for Dep. Life if also covered as an employee of the AR Public School Group.***

Child(ren):
$2,500 - 3 years of age and over
$1,000 - 14 days of age to 3 years of age

**Monthly Premium $1.20**

### Monthly Premium

Supplemental Employee Life **$**_____

Dependent Life **$**_____

**Total Monthly Premium $**_____

In signing below, I (a) represent that the statements and answers given on all pages of this application, are true, complete and correctly recorded to the best of my knowledge and belief; (b) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc., having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (d) agree that this authorization shall be valid for two (2) years from the application date; (e) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (f) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act; and (g) acknowledge receipt of the Insurance Fraud Warning. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void this policy.

**Insurance Fraud Warning** - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

**DATE OF APPLICATION**

**MONTH/DAY/YEAR** | **EMPLOYEE SIGNATURE**

**MONTH/DAY/YEAR** | **SIGNATURE OF EMPLOYER/WITNESS** | **PRINTED NAME OF EMPLOYER/WITNESS**

| Employee Name (First, M.I. Last) | Social Security # | Employer | Group # AS004404-____ |
|---|---|---|---|
| | | | |

## BASIC AND SUPPLEMENTAL LIFE/AD&D BENEFICIARY DESIGNATION

**I hereby designate the following (beneficiaries) under this Plan and revoke any existing beneficiary designation I may have made for basic and/or supplemental life/AD&D insurance benefits. I understand that this change must be on a form acceptable to USAble Life and received at our Home Office. I further acknowledge that any designation or change will be effective the date made, subject to any payment USAble Life may have made before it is received.**

## PRIMARY BENEFICIARY(IES) [Will receive proceeds if living at death of Employee.]:

| Last Name | First Name | MI | SSN | Birthdate | Relationship | Percentage |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | **Total** | = (Total must equal 100%) |

## CONTINGENT BENEFICIARY(IES) [Will receive proceeds if Primary Beneficiary(ies) are not living.]:

| Last Name | First Name | MI | SSN | Birthdate | Relationship | Percentage |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | **Total** | = (Total must equal 100%) |

**Complete this section only if applying for Supplemental Life or Dependent Life more than 31 days after your hire date. Complete the information below on yourself *(if applying for Supplemental Life)* and on your dependents *(if applying for Dependent Life).***

1. Have you, your spouse or children been hospitalized for any reason during the past five (5) years? ❑ No ❑ Yes
   If yes, give date, reason hospitalized and name of person hospitalized:

   _____

   _____

2. Have you, your spouse or children consulted a physician in the past one (1) year? ❑ No ❑ Yes
   If yes, give name of person seen by doctor, reason seen, and name(s) of doctors seen:

   _____

   _____

3. Have you, your spouse, or children ever been diagnosed by or received treatment from a member of the medical profession for:

| | No | Yes |
|---|---|---|
| 1) Cancer or any cancer related disease? | ❑ | ❑ |
| 2) Disease of the heart or blood vessels, or had a stroke? | ❑ | ❑ |
| 3) Kidney disease or diabetes? | ❑ | ❑ |
| 4) AIDS or AIDS Related Complex, Immune Deficiency Disorder, or tested positive for antibodies to HIV? | ❑ | ❑ |
| 5) Alcohol or Drug Abuse? | ❑ | ❑ |
| 6) Lung, Liver or Blood Disorder? | ❑ | ❑ |
| 7) Emotional, Nervous System or Mental Health Problems? | ❑ | ❑ |
| 8) Hypertension (high blood pressure)? (Give last two blood pressure readings, dates, medication taken, and medication dosage below)? | ❑ | ❑ |

GIVE DETAILS TO ANY "YES" ANSWERS TO QUESTION 3 above, including name of person, diagnosis, and dates of treatment:

_____

_____

4. Do you, your spouse or children have any impairments, diseases or illnesses not covered in questions 1, 2, or 3? ❑ No ❑ Yes
   If yes, give details, including name of person, diagnosis, and dates of treatment:

   _____

   _____

5. Are you, your spouse or children currently taking medication(s)? ❑ No ❑ Yes If yes, give name of person, medication(s) and dosage:

   _____

   _____

6. Name, address, and phone number of personal physician(s):

   _____

   _____

USAble Life

P.O. Box 1650
Little Rock, AR 72203

# NOTICE FOR PROPOSED INSURED

**Notice of Insurance Information Practices**
In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also seek information from others, such as medical professionals who have treated you. In some cases, we may ask a consumer reporting agency to collect information and submit an investigative consumer report to us. You have the right to request to be interviewed in connection with the preparation of that report. You may receive a copy of the report upon request.

You have the right to be told about, and to see and copy if you wish, items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THOSE PRACTICES, PLEASE SEND YOUR REQUEST TO THE CHIEF UNDERWRITER, P.O. Box 1650, Little Rock, AR 72203

**Insurance Fraud Warning**
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

**Federal Fair Credit Reporting Act Notice**
In connection with your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to the Company.

**Medical Information Bureau Disclosure Notice**
Information regarding your insurability will be treated as confidential. USAble Life or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (Bureau), a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: Post Office Box 105, Essex Station, Boston, Massachusetts 02112, Tel. (617) 426-3660.

USAble Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.